Thinking Errors in Co-Occurring Substance Abuse And Mental Health Treatment: The Inner Game of Reason

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I. Dual Disorder

Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse
Treatment Improvement Protocol (TIP) Series 9

http://www.dualdiagnosis.org/library/tip9/tip1.html
http://www.helpguide.org/mental/dual.htm

Alcohol and Other Drug (AOD) Use and Psychiatric Symptoms

- AOD use can cause psychiatric symptoms and mimic psychiatric syndromes.
- AOD use can initiate or exacerbate a psychiatric disorder.
- AOD use can mask psychiatric symptoms and syndromes.
- AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes.
- Psychiatric and AOD use disorders can independently coexist.
- Psychiatric behaviors can mimic AOD use problems.

The Terminology of Dual Disorders

The phrase **Dual Disorders** denotes the coexistence of two independent (but invariably interactive) disorders, and is the preferred term used in this Treatment Improvement Protocol (TIP).

Common examples of dual disorders

- Major depression with cocaine or methamphetamine addiction
- Alcohol addiction with panic disorder and depression
- Alcohol and polydrug addiction with schizophrenia
- Borderline personality disorder with episodic polydrug abuse.
- Some patients have more than two disorders, such as cocaine addiction, personality disorder, and AIDS. The principles that apply to dual disorders generally apply also to multiple disorders.

Profiles of patients with dual disorders demonstrate that they are more or differently disabled and require more services than patients with a single disorder. They have higher rates of homelessness and legal and medical problems. They have more frequent and longer hospitalizations and higher acute care utilization rates. For example, among patients with schizophrenia, episodes of violence and suicide are twice as likely to occur among those who abuse street drugs as among those who do not.

ABC Model for Psychiatric Screening

Appearance, alertness, affect, and anxiety:

General appearance, hygiene, and dress.
How Alert? What is the level of consciousness?
Affect: Elation or depression: gestures, facial expression, and speech.
Anxiety: Is the individual nervous, phobic, or panicky?

Behavior:

Movements:
Rate (Hyperactive, hypoactive, abrupt, or constant?).
Organization:
Coherent and goal-oriented?
Purpose: Bizarre, stereotypical, dangerous, or impulsive?
Speech: Rate, organization, coherence, and content.

Cognition:

Orientation: Person, place, time, and condition.
Calculation
Memory and simple tasks
Reasoning
Insight, judgment, problem solving
Coherence: incoherent ideas, delusions, and hallucinations?

Sequence of Treatment:

Engagement connecting with the patient's primary motivation

Assessment

> The assessment should consider criminal thinking patterns, such as rationalization and justification for maladaptive behaviors. There is a special need to establish collateral contacts and to assess for criminal history and the relationship of AOD use to behavior.

Crisis Stabilization

Longer-Term Care

Individual Counseling

Corral. Corralling means coordinating treatment with other professionals, establishing a system of communications with other professionals and with the patient, contracting patients to be responsible for their AOD use

Risk Assessment

- Suicide plans, means, and intent
- Delusions and command hallucinations
- Impulsivity or impaired judgment or cognition
- History of suicidal or homicidal behaviors.

II. Errors in Thinking: Traditional Approaches

A. Samenow, Koerner, etc.

Criminal Thinking Error	Emphasized in the following Mental Disorders
Closed Thinking	Sociopathy, Depression, Psychotic Disorder, Brain Damage
Victimstance	Depression
Views Self as Good Person	Narcissistic Disorder, Addictive Denial
Lack of Effort	Depression, Sociopathy
Lack of Interest in Responsible Actions	Depression, Sociopathy, Explosive Disorders
Lack of Time Perspective	Anxiety Disorder, Depression, Sociopathy
Fear of Fear	Anxiety Disorder, Psychotic Disorder, Explosive Disorders
Power Thrust	Sociopathy
Uniqueness	Narcissistic Disorder
Ownership (Self-Entitlement) Attitude	Narcissistic Disorder
Avoidance of Responsibility	Sociopathy, Narcissistic Disorder, Depression, Psychotic Disorder

B. Ellis, Beck and others: Core Irrational Beliefs

Criminal Thinking Error	Related to Core Irrational Beliefs
Closed Thinking	Certain acts are awful or wicked, and people who perform them should be severely punished It is horrible when things are not the way I would like them to be
Victimstance	It is horrible when things are not the way I would like them to be Because something once affected my life, it will indefinitely affect it. I have virtually no control over my emotions and cannot help having certain feelings
Views Self as Good Person	I should be loved by everyone for everything I do One must have perfect and certain self control
Lack of Effort	It is better to avoid life's problems, if possible, than to face them
Lack of Interest in Responsible Actions	It is better to avoid life's problems, if possible, than to face them
Lack of Time Perspective	Because something once affected my life, or now affects me, it will indefinitely affect me.
Fear of Fear	If something may be dangerous or fearsome, I should be terribly upset about it
Power Thrust	I should be loved and respected by everyone for everything I do
Uniqueness	I should be thoroughly competent, intelligent and achieving in all respects
Ownership (Self-Entitlement) Attitude	Certain acts are awful or wicked, and people who perform them should be severely punished It is horrible when things are not the way I would like them to be
Avoidance of Responsibility	Happiness can be achieved by inertia and inaction

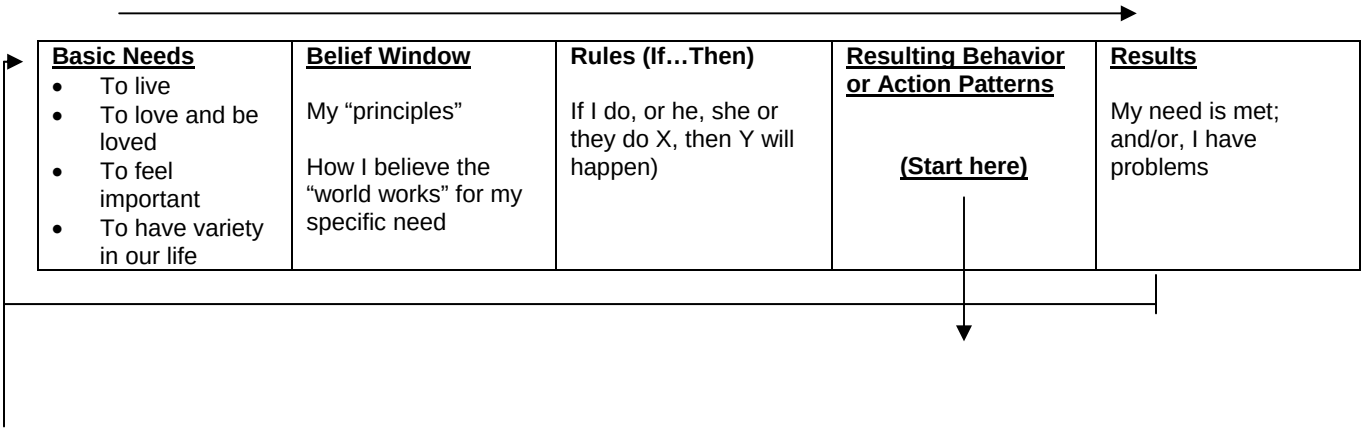
C. Franklin Reality Model: *"How we meet our needs"*

The Importance of Our Thoughts and Attitudes:

a. Our thoughts and attitudes control our actions and feelings
b. Our thoughts and attitudes usually are automatic
c. Sometimes these automatic thoughts and attitudes lead to problems and trouble

Correcting Our Problem Thought Patterns:

- We can learn to pay attention (observe) our thoughts and attitudes
- We can learn to see helpful or harmful patterns in our thoughts and attitudes
- We can learn to change problem patterns in our thinking and attitudes
- By trying new thoughts and attitudes, we can change our behavior and achieve more of our desired outcomes without getting in trouble or harming others



D. Internal Triggers to Anger, Depression and Anxiety

- "I give up, I don't care" attitude
- Failing to think clearly
- Giving in to rapid mood swings
- Ignoring signs of stress build-up
- Dwelling on thoughts of shame, guilt, hopelessness
- Defensive self-talk or rash statements in reaction to others' comments or actions
- Becoming over-involved with certain thoughts
- Focus on one thing without seeing a "bigger picture"
- Failing to problem-solve and plan
- Wishful thinking
- Thoughts leading to anger and irritability
- Not thinking about basic personal needs – food, rest, hygiene and appearance.
- Self pity
- Rejecting help/suggestions from others
- Not telling the truth (to cover or avoid some thought, feeling or circumstance)
- Loss of self-confidence
- Holding resentments – old and new
- Shift from "Recovery" thinking to "failure" thinking

E. Training in Detached Reasoning:

Logical Debate A Rational Argument Exercise for Clients

A Logical Debate is a 1:1, persuasive, non-emotional argument on a specific issue of importance. The participants will be evaluated on the quality of their analysis, use of evidence, and ability to effectively and persuasively organize, deliver, and refute arguments. Use of any "criminal tactics" (power thrusting, justifying one's self without objective evidence, etc.) is not allowed. The other clients will vote the outcome of the debate on, with final decision resting with Staff. Time limits are set for each section of the debate (presentation/response/rebuttals/summaries).

The argument must be initiated and presented in the affirmative: "something happened or exists," not "something did not happen or does not exist."

The responder (the negative) may challenge the practical relevance of the affirmative's issue during the presentation of responder's initial position. If, at the end of the debate, the negative has convinced the audience that the affirmative proposal has no practical relevance, then the decision in that debate should be awarded to the negative by vote and Staff decision.

The plan for addressing the issue presented by the affirmative must stay within the boundaries of the topic of the argument. However, the plan does not need to deal with all the possible problem areas suggested by the argument. Staff will function as Moderator, calling attention to moments when either party strays from the specific topic of argument. After such comment by the Moderator, it is the responsibility of the two debaters to decide how to continue the argument within the boundaries of the topic at hand.

The affirmative must prove that:

1. A problem or problems exists with the present situation or that a comparative advantage or goal can be achieved over the present situation;

2. There are current factors that prevent solving those problems or achieving those advantages or goals; and,

3. The proposed solution will resolve the problem(s) or achieve the advantage or goal claimed by affirmative.

The negative will challenge any of these issues, but need only win one to win the debate. The negative may also challenge the relevance of the affirmative proposal or argue that disadvantages to the proposal outweigh its benefits.

The plan need not be detailed, but should be sufficient to prove a possibility to solve the problem area. The affirmative need only prove that the resolution should be adopted and that the plan may work by specific and identifiable agent/agents of change.

Definitions of terms in the affirmative constructive are required.

The negative may present one counterproposal specific to the affirmative problem area. By this, we mean that the counterproposal must deal with the problem area defined by the affirmative, and not re-define the problem in different terms.

Counterproposals should be used to demonstrate that a reasonable alternative plan would lead to a better outcome than either the status quo or the affirmative plan. Counterproposals should be logically consistent with all other negative arguments constructed during the debate. If inconsistencies arise and the affirmative points them out, the voters and staff should reject the arguments inconsistent with the counterproposal. Counterproposals are subject to the same three burdens of proof as are required for affirmative plans.

Rebuttals are to be used to respond to the opposition's lines of argument and to extend arguments made in the argument's first presentation/response. No new lines of argument may be presented in rebuttals. New lines of argument are those that are not clarifications or responses made to arguments made in the first presentation/response, but those that are new and unrelated to previous lines of argumentation. New evidence to extend or clarify constructive arguments is permitted in rebuttal.

All presentations/responses/rebuttals should be pleasant, comprehensible, and persuasive in tone. Speech delivery and quantity of evidence should not be excessive. Staff will give a verbal warning to debaters speaking too rapidly in

a round. If the speaker does not heed the warning in that particular round, the Staff is strongly encouraged to give that speaker a loss for that round even if the student has otherwise "won" the debate on the basis of the issues.

At the end of the debate, clients and Staff will give feedback regarding examples of positive use of logical argument vs. appeal to emotion or use of errors in thinking.

Rules Evidence In Debate

Participants in a debate should only use evidence that is accurate and thoroughly referenced in their speeches.

All evidence must be from a named source, easily available to the other clients and staff, and easily verifiable.

For the purpose of this exercise, verbal and hearsay evidence may be quoted and must be documented and dated in writing, only if the person quoted is named, agrees to be quoted, available to voters and staff to be questioned if necessary, and subject to approval of voters and staff.)

The debaters should use evidence that is accurately and directly quoted. The evidence should be quoted with in context of the original source. When relevant, the debater must state the full source when introducing the evidence. A "full source" is assumed to include source's name, qualifications, and date given (or date published, if printed). Once a source has been cited, evidence subsequently cited from the source need only include the source's name as well as a phrase along the lines of "previously cited." Both speakers in a debate are required to make available to their opponent copies of any evidence used in the round, including the opening affirmative presentation speech. The evidence must be returned to the speaker at the end of the debate.

If a debater, during the course of the debate, charges his/her opponent with violating any rule of debate or behavior, the debate shall immediately cease. The Staff and voters will discuss the charge and make a decision, with ultimate Staff approval, whether or not the debate will continue, and under what additional constructive guidelines, if any.

III. Errors in Thinking: New Approaches

A. Paradigm Shift

In 1962, Thomas Kuhn wrote The Structure of Scientific Revolution, and fathered, defined and popularized the concept of "paradigm shift".

Kuhn argues that scientific advancement is not evolutionary, but rather is a series of peaceful interludes alternating with intellectually dramatic revolutions, and in those revolutions "one conceptual world view is replaced by another".

The accumulation of difficulties in traditional methods triggers a crisis that can only be resolved by an intellectual revolution that replaces an old paradigm with a new one.

B. Neurochemical Foundations of Symptoms in Addiction, Mental Illness, and Normal Emotions – A Paradigm Shift in Methods of Treatment

Addiction	**Mental Illness**	**Normal Emotions**	**Some Effects**
Dopamine	Dopamine	Dopamine	Sense of Well-being High Alertness Focused Attention “Reward”
Serotonin	Serotonin	Serotonin	Relaxation
Norepinephrine	Norepinephrine	Norepinephrine	Global Stimulation Energy
GABA	GABA	GABA	Global Suppression of Stimuli
Corticotrophin Releasing Factor	Corticotrophin Releasing Factor	Corticotrophin Releasing Factor	Production of Cortisone – long-term stress effects on body

Factors that affect these neurotransmitters may be compared with playing keys on a piano – a complex combination of inputs and a complex results, but the results "*make sense"* in predictable patterns *coming from the whole "piano system"* (major/minor, loud/soft, fast/slow), not just from the way any one key is played. Understanding this may require a paradigm shift in how we think about treating dual disorder clients.

KEYNOTE: New and better ways of thinking in our clients with addiction and mental disorder may be enhanced by creating interventions that awaken a similar, mild pattern of positive emotional states as did the substances they abused. On the other hand, traditional interventions that awaken stress and negative cognition/feeling may a) limit new and improved thinking and b) strengthen the neurochemical patterns that relate to craving and relapse.

C. Research Findings[1]

1. Many of the behaviors and cognitive benefits of positive emotion are mediated by the dopamine system.
2. Creative problem solving is improved because conditions of positive emotion are associated with increased dopamine levels in the frontal cortex. Conversely, lack of constructive emotional involvement in a situation is related to reduced levels of dopamine.
3. Positive emotion leads to greater cognitive flexibility and helps improve problem-solving across a broad range of settings
4. Positive emotion increases a person's ability to organize ideas in multiple ways and consider alternative cognitive points of view
5. Positive emotion increases the probability that people will pursue problem solving in a way that leads to improved outcomes for all parties involved.
6. Positive emotion increases flexibility and "variety seeking" – considering a wider range of possible solutions
7. Under conditions of positive emotion, people are less defensive and can better focus on negative information that is necessary for solving a problem.
8. Positive emotion and related changes in dopamine and norepinephrine result in improved memory and learning
9. Techniques of eliciting and cultivating positive emotions are suited to preventing and treating problems involving anxiety, depression, aggression and stress-related health problems.
10. Negative emotions narrow a person's response repertoire to fewer; stereotypic behaviors and thoughts intended to serve ancient needs of survival (fight/flight).
11. Positive emotions "broaden and build" adaptive thinking patterns – "resource building"

[1.] Material summarized from Ashby et al, "A Neuropsychological Theory of Positive Affect and Its Influence on Cognition." Psych Review 1999, Vol. 106 No. 3, 529-550; and, Frederickson, Barbara, "Cultivating Positive Emotions to Optimize Health and Well-Being." Prevention and Treatment 2000, Vol. 3, Article 0001a, American Psychological Association, posted March 7, 2000.

D. Reformulating the Practice of Corrective Thinking Intervention

1. A Compassionate Context for Errors of Thinking: We all share in facing the Facts of Life

The Facts of Life

I am grateful for so much in my live

Crap happens.

1. All persons and things change with time.
2. Change – both pleasant and unpleasant - usually happens at a time different than I want or expect – often change is very UNexpected.
3. I carry a set of "rules" (expectations) about how I expect or want people and things to work, but people and things often do not work according to my "rules" or expectations.
4. Nevertheless, I continue to hold to our personal rules and expectations.
5. When applied to what actually happens, or what people really do, my personal "rules" are often <u>unenforceable.</u> (If so-and-so happened, then I/they <u>must</u> do X, Y, or Z.)
6. If I continue to hold unenforceable rules in response to the real world and people around us, I experience pain (anger, depression, anxiety).
7. If I allow myself to meet the world and people around me without trying to enforce my unenforceable rules, I am open to more peaceful feelings and creative solutions.
8. Strong emotions awaken more "primitive" parts of the brain and get in the way of good problem solving, but I can practice shifting from strong emotions to a more neutral state of mind, then think more clearly of way<u>s</u> to solve the problem.
9. One test of my words or behavior is: "does it help to solve the problem, and does it bring me more peace?"
10. I usually do what ever is possible to avoid what is unpleasant and more toward what I perceive to be pleasant.
11. However, the specific ways I try to avoid pain and seek pleasure often produce just the opposite of my intentions, because my choices are rooted in emotional over-attachment to specific results.
12. The "detachment" so often spoken of in Recovery is the skill of turning down the volume on my emotional attachment to specific results.

E. Meditation, Yoga, guided imagery, etc. – methods for moving from negative neurochemical depletion to neutral or mildly positive neurochemical enhancement.

F. Specifically, the practice of "Mindfulness" allows the experience of emotional contentment to emerge and teaches a new approach to thinking based on awareness and acceptance rather than conflict/rigidity.

1. The Lazy Man's Guide to Mindfulness:

   Focused Breathing

   With full attention on the act of breathing, take gentle "belly breaths" and count backwards from 15 with each exhalation. Become aware of mental distractions, accept them and return to breathing, beginning again with 15.

   Forgiving Centering ("letting go")

*As you take in and let go of one breath, say or think **one** of the following with **that** breath.*

1. *May I be content*
2. *May I be healthy, strong and whole*
3. *May I have all that I need*
4. *May I be safe and free from harm*
5. *May I be at peace*

Repeat steps 1 – 5, substituting the name of one you love
Repeat steps 1 – 5, hearing the words said to you from one you love
Repeat steps 1 – 5, substituting the name of one for whom you have resentment
Repeat steps 1 – 5, hearing the words said to you by the person you resent

[When done in group, take time to process the clients' experiences – both enhancing and blocked – and adapt the practice to certain individuals as indicated by their needs.]

G. Appreciative Inquiry: A new approach to creating a positive future in Dual Disorder recovery
   Developed by David Cooperrider, Ph.D., Case Western Reserve University, Cleveland, Ohio, as a method of change in organizations

   1. Our words create our own realities
   2. Change begins by asking appreciative questions
   3. Change continues by holding images of the future rooted in moments of greatest success in the past
   4. The more positive the question, the greater and longer-lasting the change

H. Appreciative Four-Stage Process:

   1. Discovery (the best of what is – what gives life to _____?)
   2. Dream (what might be)
   3. Design (how to bring it into being)
   4. Destiny (how to keep the positive changes by learning and adjusting)

I. Appreciative Inquiry for Emotionally Balanced Recovery

(Facilitator asks questions; clients write responses privately, and then take turns sharing the responses with one person while the rest of the group listens)

1. Think about a time that you felt you were truly "sober, free and clean."

- Write the story.
- Why was that time so powerful?
- What are the good things about you that helped make this a special and successful time?
- What did you learn new about yourself during that time?
- Who else was involved and how did they help?
- Was there anything else that helped make this time special?

2. When we are in healthy recovery, sometimes we need help and care from others. From time to time we have the opportunity to experience such wonderful help and care given to us.

    - Tell the story of this wonderful help and care that you received.
    - What made it so special?
    - How did you help too?
    - Was there anything else that made this experience so different?

3. Persons in healthy recovery take an active role in making decisions to stay emotionally balanced, free and clean and to help their families join in their emotional and substance recovery.

- Tell the story about how you made an important decision about your own recovery or when someone in your family was having problems related to recovery
- How did you know what to do?
- What was it about you that enabled you to make these decisions?

(After all have shared, the Facilitator asks the group to identify common Themes of successful, emotionally balanced recovery):

- What successful elements do all your stories share in common?
- What could you each do now to achieve similar success?
- What could others do to help you continue your success?

Imagine that you lived in a truly healthy, emotionally balanced, recovering family and in a community that supported your success.

- What would be different from the way things are now?
- What could you do right now, today, to move into the future you see in your mind?
- What steps could your family and community take now to insure a healthy recovery future?

(Based on the answers to this debriefing, the Facilitator asks clients to develop a list of "Provocative Propositions." These are statements in the present tense that stretch the limits of defining a successful future in emotionally balanced recovery. The following qualities define a "Provocative Proposition:"

- A Self-directive that stretches and challenges without appeal to shame/guilt or manipulation
- Grounded in reality – moments in the past when the best desired behaviors actually occurred
- The client desires it both emotionally and cognitively: he/she really wants it and knows why
- It is stated in affirmative, bold, present tense terms
- Some include use of third-party viewpoint (how others would appreciate the client's behavior)
- It reinforces the 2:1 rule of positive thoughts?
- Some include plans for cooperation with others to accomplish the intended proposition
- Each Proposition is stated only in terms of **Today,** to strengthen "one-day-at-a-time" recovery

Examples will be gathered from today's group role-play exercise. They could include:
- Today I read my "One Day at a Time" and apply the thought for the day to my recovery
- Today I write in my journal that I am keeping for my son to help him understand my recovery
- Today I will associate only with persons who are free and clean.
- Etc.

Each day give your best energy to doing these directives.